



Wellspring Psychology

475 Alberto Way • Suite #180 • Los Gatos, CA 95032 •
WellspringPsychology.com •

Confidential Client Data Form

CONTACT INFORMATION

Date: _____

Name: _____

D.O.B: _____

Street Address:

City/State/Zip: _____

OK to send mail? Yes No

OK to call? Yes No Which number? _____

OK to leave message? Yes No Which number? _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Email: _____

OK to email? Yes No

Please provide a name and phone number of whom to call in case of an emergency:

DEMOGRAPHIC INFORMATION

Gender: _____

Relationship Status: _____

Ethnicity: _____

Employer/Occupation: _____

Education / Degrees: _____

REFERRAL INFORMATION

Current reason(s) for seeking therapy:

Estimate the severity of the above problem:

Mild Moderate Severe Very Severe

How did you hear about our practice?

HEALTH INFORMATION

Do you have any current medical conditions?

Are you currently taking any medications? (Please list names, dosages, and prescriber):

Have you ever been hospitalized for psychiatric reasons? (If yes, please provide details):

Have you previously been in psychotherapy? When and for what issues?

Was it helpful?

Do you have any previous suicide attempts, self-destructive behaviors, or violent behaviors?

List any past/present drug and alcohol use.

RELATIONSHIPS

Do you live with others?

Are there any other current relationships that are a significant focus in your life right now? Please describe:

Other

What are your main worries or fears?

What do you consider your main strengths?

Please add any additional information that may be helpful to our work together:



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Agreement to Pay for Professional Services

I request that a clinician from Wellspring Psychology provide professional services to me and agree to pay \$ _____ per session for such services.

I agree that this financial relationship with this therapist will continue as long as the therapist provides services, or until I inform him/her that I wish to terminate treatment. I agree to meet with this therapist at least once before stopping therapy. I agree to pay for services provided to me up until the time I end the relationship.

I agree that I am responsible for the charges for services provided by this therapist to me, although other persons or insurance companies may make payments on my account. Medicare patients please be advised that per CMS guidelines, patients are responsible for the full fee of phone sessions.

I also understand and agree to Wellspring Psychology's 48-hour cancellation policy and understand that if I am unable to provide this notice, I will be charged for the full fee of the missed session.

_____ Signature of client

_____ Date

_____ Printed name

Assignment of Benefits: I hereby assign medical benefits, including those from government-sponsored programs and other health plans, to be paid to the therapist listed on this form. Medicare regulations may apply. A photocopy of this assignment is to be considered as good as the original.

_____ Signature of client

_____ Date

_____ Printed name

Credit Card on File

Credit Card #: _____

Expiration Date: _____

CVV code: _____

Zip Code of Billing Address: _____

Signature of client: _____

Printed name: _____

Date : _____

If you plan to bill your insurance company for sessions, please provide your therapist with your insurance card at this time to make a copy of for our records.



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Acknowledgment of Notifications

I acknowledge that I have received Wellspring Psychology's Office Policies and Consent for Psychotherapy Services and I understand, and agree to comply with these policies. I understand that these policies will always be available to me at www.WellspringPsychology.com, and that I may always request a hard copy if I am unable to access them.

I understand that my clinician is operating under a valid license in the state of California.

_____ Signature

_____ Date

_____ Printed Name

I also acknowledge that I have received the HIPAA Notice of Privacy Practices for my review. I understand that the HIPPA form will remain available at www.WellspringPsychology.com, and that I may always request a hard copy if I am unable to access it.

_____ Signature

_____ Date

_____ Printed Name



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Authorization to Release Information

I, _____, the undersigned, give permission to my clinician at Wellspring Psychology to release and provide the following information (check all that apply)

- participate in my treatment as collateral
- my attendance in therapy
- my diagnosis
- my treatment plan
- information relevant to coordinating care
- other (please explain in detail)

to:

(Name) _____

(Address) _____

(Phone Number) _____

(Fax Number) _____

I understand that that this release is valid for a period of 1 year. I further understand that I may revoke this authorization at any time in writing. In consideration of this consent, I hereby release the above parties from any legal liability resulting from the release of this information.

Signature Date